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SUICIDES IN NEW YORK CITY PRISONS: AUGUST 8 - OCTOBER 3, 1976

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During the last eight weeks, from August 8 to October 3, 1976, six inmates under the care of the New York City Department of Correction have committed suicide. Four were housed at the New York City House of Detention for Men on Rikers Island while the most recent such deaths occurred last Sunday, October 3, at the Adolescent Reception and Detention Center, and last Wednesday, September 29, at the Correctional Institution for Men.

The following report summarizes what we now know about the first four of these deaths. We are still in the process of compiling preliminary reports on the most recent suicides. Even with regard to the first four, there are still a number of unanswered questions about what took place. Presumably, an investigation currently being done by the City's Department of Investigation will clear up most of these issues. Apart from such an account, however, there are a number of conclusions that can already be reached. The facts uncovered so far strongly suggest measures which should be taken by the Department of Correction and the agencies affiliated with it to reduce the likelihood of further prison suicides. These are discussed at the end of this report.

Many of these suggestions are in fact already part of Department of Correction policy or that of the Health Department's Prison Health Services. Unfortunately, as the following cases imply, there is no guarantee that existing policy is being carried out. Most of the remaining suggestions have been offered before, either by the Board of Correction in earlier reports or by other agencies concerned about suicides in our prisons. What remains is to implement them.

It is often said that if someone is intent on committing suicide, it is impossible to stop him; he will always find a way. The truth of that assertion implies that we are already making the greatest effort we can to avoid these deaths. In the context of the City's prison system that would mean that the suicide prevention procedures currently in force are already the most effective that can realistically be employed; and that they are carefully and diligently followed by the doctors, nurses, correction officers, administrators, and suicide prevention aides who must implement them. Based on what is already known about the deaths of Tracy Ford, Pierre Sadler, Joseph Anderson, Simon Fratichelly, Fernando Moto and Duane Harris, it is clear that is not the case.

1. DEATH OF TRACY FORD

Tracy Ford was a black man from the Bronx. On June 26, 1976, he was denied bail and was committed to the custody of the New York City Department of Correction pending trial on a charge of attempted murder. Forty-three days later, on August 8, he was found hanging in his cell in 5 Block of the New York City House of Detention for Men (HDM).

Upon admission to the system in June, Ford stated that he was 19 years old, an adolescent. Accordingly he was housed at the New York City Adolescent Reception and Detention Center (ARDC) where male detainees below the age of 21 are kept. On or about August 6, military discharge papers were found at ARDC that established his age as 22 years. Despite the fact that young men often lie about their age to gain admission to the military, this age was accepted and in the absence of contrary information, Tracy Ford was transferred to HDM, an adult institution. There he was placed in a general population cell-block housing over 200 inmates.

The Board has since learned that Mr. Ford was in fact still an adolescent. A copy of his birth certificate shows that he was born on November 5, 1956, and was, therefore, only 19 years old when he was sent to HDM.

The Board has also learned that Ford was apprehensive about being transferred to "the blocks" and communicated this fear to a fellow prisoner who was also being transferred. Such apprehension is not surprising. HDM is an ominous physical plant, over 40 years old, a reminder of a history that correction might well repudiate. Its fortress-like structure, three-tiered cellblocks, and immense size are unsettling even to seasoned inmates and correction officers.* HDM's design is diametrically opposed to the campus-like atmosphere and modern construction of ARDC.

While still at ARDC, Tracy Ford gave every indication of being a seriously disturbed young man. On June 28, as the result of a court order, he was transferred to Bellevue Hospital pursuant to a section 730 commitment for psychiatric evaluation. The Bellevue examination found him to be competent for purposes of standing trial. Following his return from Bellevue to ARDC on August 3, he was sent to C-71, the Rikers Island Mental Health Center, for further evaluation. The evaluation at C-71 determined that he was fit for general population at ARDC. In view of his later behavior, that judgment must be seriously questioned and the criteria used reexamined. In any case, it was on the strength of that determination that he was immediately put into general population housing at HDM following his transfer.

Ford was involved in two incidents while at ARDC which gave further indication of behavior problems. On June 28, while being escorted from the clinic to the receiving room, he fought with two officers, biting one on the hand and kicking the other. On another occasion, while in the clinic, he reportedly put his head through a

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*See Report on the New York City House of Detention for Men, New York City Board of Correction, June 1975, for a more detailed discussion of HDM's physical layout.

glass window. It is not clear from the record what caused either incident. Whatever his problems or the degree of accuracy of the psychiatric pronouncements concerning them, one thing is clear. At 6:25 a.m. on August 8, two days after being transferred to HDM, Tracy Ford was found dead in his cell, a suicide.

The inmates who housed with him in 5 Block contend that Tracy Ford did not belong in general population. They say his behavior was observably unusual. He was withdrawn and reclusive; was not eating, sleeping or communicating. They say he kept to himself, remaining on his tier or in his cell, rather than joining the other inmates "on the flats" during lock-out periods. Unfortunately, this is the kind of "unusual" behavior that is least likely to be noticed in the confusion of a general population cellblock at HDM.

In any case, according to records available at the institution, the correction officers with responsibility for the area made their regular patrols up and down the tiers during the night of August 7-8 and saw nothing unusual. At 6:25 a.m., Ford was discovered kneeling in his cell by another inmate. He was facing the bunk, with an improvised rope attached to the upper-bunk support post. The inmate alerted the "C" officer to the emergency. He in turn informed the other officers in the block and efforts to revive Ford began. Approximately five minutes later, superior officers and medical personnel arrived at the cell and assumed responsibility for the resuscitation attempt. Some of the institutional reports indicate that the medical personnel arrived at 6:40 a.m. rather than 6:30 a.m. The discrepancy between the two versions is not explained.

After completing his examination, the doctor pronounced Tracy Ford dead and estimated that he had expired 10 minutes earlier. The medical examiner who was on the scene between 8 and 9:25 a.m. found the body to be in a moderate state of rigor mortis at the time of his examination. Some of the other inmates on Block 5 disagree with the doctor's conclusion. They claim the body was cold when they found it, indicating that Ford had expired at some time during the night and not a few minutes earlier.

2. DEATH OF PIERRE SADLER

Pierre Sadler, a 21-year-old black man, was admitted to HDM in the early morning hours of August 10, 1976, on remand from the Bronx Criminal Court. According to Department of Correction records, he was charged under section 140.05 of the Penal Code with trespassing, a violation. Bail was set at $500. Although it is unusual for such a minor crime to lead to incarceration, it apparently did so in Sadler's case.

Sadler was originally assigned a cell in 3 Block at HDM, the institution's reception area. He was subsequently transferred to the mental observation area located in 8 Block.

At the time of his admission medication examination on August 10, Sadler indicated to the examiner that he had been previously hospitalized for psychiatric reasons. Specifically, the record notes "1975 Crisis Center c/o 'bad nerves.'" Whatever this notation meant specifically, it was apparently enough to justify calling Sadler to the clinic later on the 10th to discuss what the record refers to as "the Crisis Center episode." On the basis of the information gather at this consultation, the examining doctor had Sadler transferred to the mental observation area. The doctor found that Sadler "recently had recrudescence of symptoms (auditory non-command symptoms, (indecipherable), depression, and vegetative symptoms) o suicidal ideation." It is unclear whether the symbol "o" means no such ideations or--more likely--was meant to be "c," a common abbreviation for "with," used earlier in his notes by the doctor. In any case, the doctor found Sadler to be a chronic schizophrenic, ordered him to be housed in the mental observation area in 8 Block, and prescribed "Stelazine 20 mg. b.i.d. and Artane 4 mg., h.s., 2 mg. a.m."

Stelazine is a strong tranquilizer and antidepressant and Artane acts to reduce shakes due to tranquilizer dosages. "[B].i.d." indicates a dosage twice daily; "HS" stands for "hours of sleep" and "a.m." for morning. The medication administration sheet on which the actual dispensing of the medication is to be noted does not appear to have any entries under either medication. In the section devoted to "renewal date/D/C date" the word "STAT" has been inserted. "STAT" can be interpreted to indicate that treatment should begin immediately or that medication should be dispensed only once. Thus, from the record it is not entirely clear what schedule of medication the doctor intended or if medication in fact was administered.

In the days following Sadler's admission to HDM, he was apparently returned to court twice. On August 12 he was brought before the Family Court and his $500 bail continued. He appeared again the next day when he was ordered held under Article 730 for psychiatric evaluation.

The next indication on the record was entered just after 6 a.m. on Sunday, August 15, when the Suicide Prevention Aide on duty in Block 8 called to the officer on duty on the "E" post. He drew his attention to cell 6A13, a ground floor cell about halfway back in the mental observation area, where Sadler was housed. The officer went to the cell and observed Sadler with a noose around his neck kneeling in the cell facing his bunk with the noose tied to the frame of the top bunk. The officer ran back to his post, opened the cell, removed the noose

from Sadler's neck and brought him outside the cell.* The tour commander, an assistant deputy warden, happened to be in the area at the time of an inspection tour. He witnessed these events and noted in his report that the correction officer felt a faint heart beat and that he, the ADW, "detected a pulse and the body was warm except for subject's fingers which felt cool."

Artificial respiration was begun and the doctor was sent for. He arrived a few minutes later and, by his own report, found "there were no spontaneous respirations noted, pupils dilated, body warm, extremities cold. There was a distant cardiac beat noted which was short termed." Sadler did not respond to the efforts to revive him and at 6:30 a.m. was pronounced dead. The representative of the medical examiner's office who arrived at the scene sometime after 8 a.m. noted in his report that there was not yet any sign of rigor mortis.

To this point in the account of what occurred all those interviewed, or whose versions appear in the institutional records, basically agree on what transpired. Where they differ, and differ significantly, is on what happened during the night preceding Sadler's death.

According to the tour commander's report, the officer assigned to the M.O. area on the midnight to 8:30 a.m. tour on Sunday, August 15, reported that both he and the suicide aide made all their tours of inspection. He apparently told the ADW that he did not patrol "routinely" but rather "staggered" his patrols. However, the log book filled out by the officer indicates that he made regular tours on the half hour during the night.

When asked by the tour commander whether Sadler had given any signs of impending suicide, the officer reportedly said he "had no problems with subject." A report filled out by a captain, who also responded to the scene and who was in charge of Block 8 during the midnight tour, concluded that "there was no evidence of foul play nor any indication that above inmate would attempt to commit suicide." Both the Captain and the ADW's report mention that no suicide note was found and that there was no personal property in the cell.

There are, however, contrary indications that some notice of a possible suicide attempt was given. First, there is the ambiguous notation already mentioned in the doctor's consultation report regarding suicidal ideation. Second, the ADW in his report says, "However a criminal court order for psychiatric examination article 730 in the comments of the court it is written in "Suicide Watch" dated 8/13/76

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*The reports of the correction officer assigned to the area, the captain in charge and the tour commander all note that the noose was loosely tied and was easily removed.

signed by Judge Tyler."* The source for that statement does not appear in the papers supplied to the Board of Correction. In any case, there is no indication either with regard to the court order or to the doctor's evaluation of Sadler that the information was ever communicated either to the officer on duty or to the suicide prevention aides in Block B.

Finally, in the course of its investigation, the Board has received allegations which raise serious questions about the circumstances of Mr. Sadler's death, the lack of any prior notice of a suicide attempt, and the official version of what took place. These statements have been turned over to the Department of Investigation for study.

3. DEATH OF JOSEPH ANDERSON

Joseph Anderson was a 36-year-old white man committed to the custody of the New York City Department of Correction on August 14, 1976. He was received at HDM on Rikers Island early the next day to serve a five-day sentence on a charge of disorderly conduct. He was also awaiting disposition of a warrant charging him with robbery in the first degree.

At 1:30 a.m. Anderson was examined by a doctor of the Montefiore clinic intake staff. He was noted to be of "poor appearance" and experiencing slight tremors (emphasis in original). Librium, a tranquilizing drug, was prescribed and follow-up treatment was scheduled for the following morning. The doctor also noted that an alcohol withdrawal evaluation should be performed. Apparently, however, Anderson was not examined by medical staff the following morning nor was he given any further medication.

However, at about 12:47 p.m. on August 15, a doctor and nurse arrived at Anderson's cell on the third tier of HDM's reception area in response to an urgent summons from the correction officer on duty in the cellblock. The doctor found that Anderson was dead, an apparent suicide. He was officially pronounced dead at 12:50 p.m. Like Ford and Sadler before him, he had hanged himself from the top bunk of his cell. In all, Joseph Anderson had spent 11 hours and 20 minutes in HDM before taking his own life.

Anderson had a long history of arrests and incarcerations. He knew the penal system. He also had a history of alcohol, barbiturate, and methadone use. Upon intake, Anderson had claimed to have been using alcohol for only one year. But, at the same time, he reportedly

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*The tour commander's report correctly notes that the "NO" box on the History and Physical examination form is checked in answer to the question "is inmate suicidal?" He makes no mention of the conclusion reached or the doctor during the later consultation or the medication prescribed.

stated that his average daily consumption was nine bottles of wine (total volume or size of bottles not listed).

Sometime following his 1:30 a.m. examination, Anderson had been housed in 3 Block, 3B12 cell, a third-tier cell in the reception area. Aided by a tranquilizer, he apparently was able to sleep through the night. In the adjoining cells were inmates A and M (an Hispanic detainee who had difficulty expressing himself in English). According to A, he first spoke with Anderson after the 9:30 a.m. lockout. A explained that both Anderson and an unidentified friend of A's from the streets were waiting for medication. A's friend's condition improved, Anderson's worsened, and his apprehension concerning his situation increased. The 3 Block Suicide Aide for the 6 a.m. to 2 p.m. tour informed the Board that Anderson had asked him when the morning medication and a telephone call would be provided. He stated that he had replied "shortly."

The statements of the Aide and A corroborate that Anderson was frustrated by the apparent failure to follow through on his prescribed treatment. They described him as obsessed with securing the relief which he expected the medication to bring.

Nevertheless, A stated that Anderson was sociable and fit well into the block routine. During the 11:30 a.m. lock-in, according to A, "everyone was singing and carrying on." He said that Anderson was singing and "beating on his table like a bongo drug." At about 12:15 p.m., the Aide made his round past Anderson's cell and noticed nothing unusual. Approximately five minutes later, at 12:20 p.m., A asked Anderson for a match, but got no response. He assumed that Anderson was not there, but he is not sure why he made that assumption.

At approximately 12:32 p.m., the 8 a.m. to 4:30 p.m. "B" officer locked out the 3B tier for feeding.

A exited his cell, hung some clothes on the railing, and turned to proceed to the dayroom for lunch. At first when he peered into Anderson's cell, he thought Anderson to be joking. Then he realized that this was no joke, that the man had hanged himself, and that assistance was needed. He yelled "hang up" to the officer, who ran to the cell after alerting the "A" officer to the incident. The "A" officer, in turn, informed the control room of the situation. The control room made the necessary notifications, including the medical staff notification, at approximately 12:40 p.m. The officer, with the help of inmates A and M, was able to cut Anderson down and remove the ligature from about his neck. They placed him in a supine position on the floor and began to administer emergency resuscitative measures. At approximately 12:47 p.m., the doctor and nurse assumed responsibility for the resuscitative effort. At 12:50 p.m., Anderson was pronounced dead.

Curiously, the two superior officers who were in the superior officers' dining area were able to respond nearly two minutes faster than medical personnel coming from the clinic, a much closer area. It may be that the difference in response time reflects a difference in notification time. If so, it would suggest that the priorities for notification be examined and reordered. In any event, the reason for the delay should be determined.

Members of the Board of Correction staff were in the institution at the time of Anderson's death investigating the Sadler suicide and responded to the scene at the same time as the superior officers.

Based on what is now known about Joseph Anderson, it is difficult to understand what prompted him to take his own life. Perhaps a better understanding can be achieved once more complete information about his circumstances is obtained. Of the four deaths discussed in this report, Anderson's seems to come closest to being "unpreventable." Nevertheless it, too, raises serious issues regarding the efficacy of the initial medical interview, follow-up on prescribed treatment and the operation of a reception area. Exploration of these issues and a change in procedures reflecting what is learned from such exploration may help prevent the next suicide-prone inmate from taking his life.

4. DEATH OF SIMON FRATICHELLY

Simon Fratichelly was found hanged in Cell 2B18 in 5 Block at HDM on Rikers Island at approximately 4:05 p.m. on September 16, 1976. He was a 31-year-old Hispanic defendant from the Bronx who had entered the correction system on April 10, 1976, after his arrest under section 145 of the Penal Law, criminal mischief. On April 12, 1976, according to the accompanying card maintained at the Bronx House of Detention for Men, two warrants were lodged against him. One warrant was later dismissed on May 20, 1976, while the other resulted in prosecution for robbery in the first degree. The original charge of criminal mischief was satisfied by conditional discharge on June 29, 1976, in Part 1F of the Bronx Court. On September 14, 1976, in Part 33 of Manhattan Supreme Court, Fratichelly entered a plea of guilty to robbery in the second degree and was remanded to the custody of the Commissioner of Correction to await sentencing on October 27, 1976.

Fratichelly had made no less than 20 court-related appearances during his approximately five months in custody. He had been shuttled between four different institutions on six separate occasions, the last being a transfer from the Bronx HDM to HDM on Rikers Island. Fratichelly according to Department sources was transferred from the Bronx to Rikers Island because his current case was a Manhattan case. His Bronx case had been satisfied. It has not yet been determined why it took appoximately two months, from June 29 to August 24, to initiate this transfer following the change in status of the defendant. The change separated him from an institution with which he was familiar and felt comfortable and placed him

in a somewhat hostile environment at HDM. Fratichelly was fluent in Spanish, but he was not fluent in English, and it appears that being in the Bronx House of Detention which has a somewhat higher ratio of Hispanics to other inmates was more comfortable for the defendant. Another area of possible crisis precipitation was the severing from his community and his family that was inherent in the transfer to Rikers Island.

The medical records which were supposed to accompany the inmate when he was transferred were incomplete. Specifically, both the dispensing record of medication and special observation watch reports from Fratichelly's initial incarceration were not included. According to Prison Mental Health Services, Montefiore Clinic at HDM does not do admission physicals upon transfer inmates who are being received from other institutions in the Department. As a result, further medical treatment is contingent upon the inmate's requesting such help at some point following his transfer to the new institution. If no attention is requested or if the defendant is either unable to request such or to understand why he must now request what formerly was provided as a matter of course, no treatment, as in this case, is provided. From approximately April 12 to August 24, Fratichelly received psychotropic medications on a regular basis and through the course of various interviews indicated that he felt better when he was taking the medication. From August 24 to September 16, the length of time spent at HDM, it appears that Fratichelly received no medication whatsoever.

RECOMMENDATIONS

The problem of preventing prison suicides has been addressed by many agencies during the last few years. Drawing on this literature as well as its own past studies, the Board believes the following recommendations for both short- and long-term action will, if implemented, decrease the incidence of suicides in our jails. The source and date of any findings and recommendations originating from other agency or individual studies are cited following the suggestions.

The short-term recommendations presented herein are to some degree stopgap measures. They do not require expenditures of large sums of money which admittedly are not readily available to the Department, but they will help to prevent suicides.

The long-term recommendations are for the most part extensions of the short-term. The basic assumption of both types of recommendations is the same; that is, that observation of troubled inmates by personnel who care and are concerned prevents suicide. Hopefully, the long-term recommendations will prove cost effective and will inject into correction a professional approach to a problem which has long troubled the prison system.

Doctor Leonard M. Moss, M.D., formerly the Consulting Suicidologist to the New York City Department of Correction, proposed the crisis intervention team concept as delineated in the long-term recommendations. The Board feels that his recommendations should be heeded (see Moss, Observations on Suicidal Behavior in Prison, 1973).

Other useful source material includes the 1971 New York City Rand Institute report, Inmate Suicides: Longitudinal and Cross-Sectional Features in the New York City Department of Correction (draft), minutes of meetings of the Prison Death Review Board, and the following reports issued by the Board of Correction:

1. Report on Prison Suicides and Urgent Recommendations for Action, August 12, 1972.

2. The Death of John Wayne Wilson, July 21, 1973.

3. Inmate Suicide Prevention Aide Program: Report and Recommendations, July 26, 1973.

SUMMARY OF RECOMMENDATIONS

A. HOUSING - SHORT-TERM

1. Upper bunks, ladders and supporting rods should be removed from cells, especially in mental observation and reception areas.

In 1972, the Board said:

> "Inmates with suicidal tendencies, suffering from mental anxiety or depression, should no longer be confined in cells unless such cells are designed to meet the special safety and security needs of such prisoners."
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> "A cell with protruding fixtures, bunks, barred windows and cell-front grillwork presents a ready opportunity to an inmate bent on suicide by hanging. Visual observation of inmates confined to such cells is minimal; they can never be made suicide-proof except with constant observation, literally round-the-clock."

These kinds of alterations in cell design to remove projections from which nooses can be hung must be completed without further delay. Evidence since the issuance of the Board's 1972 report continues to support the recommendation. In all four cases delineated in this report, the upper bunk structure was used to anchor the noose. With the advent of court-ordered single-celling in the City's detention institutions, there is no longer any need for upper bunks.

2. Every effort should be made to house high-risk cases at institutions other than HDM.

By its very design, HDM is undoubtedly the most crisis precipitating institution. The New York City HDM has 1,870 cells and no dormitories. Its large impersonal cellblocks are both physically frightening and depressing and extremely difficult to observe.

3. To the extent that HDM must be used, new admissions and mental observation inmates must be housed on the lower two tiers where observation is more easily conducted. Any inmates with identified suicide ideation should be housed without material which could be used to kill themselves and close to the front of the cellblock nearest the correction officer's post.

B. HOUSING - LONG-TERM

4. Inmates identified as suicidal should be housed in dormitories rather than cells.

Two separate studies of suicides in the New York City correctional system have shown that in one case 89 of 100 suicides were committed in cells (Rand), and, in the other, 55 of 58 suicides were committed in cells (Moss). Both note that the remaining suicides were committed in areas other than dormitories.

A number of dormitories exist in the system and should be used for potentially suicidal inmates. They permit closet observation of behavior by correction officers and fellow inmates. This approach was used with great success at the Branch Queens Mental Health Center and was included in the design of the Mental Health Center on Rikers Island through the inclusion of so-called super-cells or mini-dorms in the original proposal. Unfortunately, budget limitations necessitated the elimination of the mini-dorms.

C. PERSONNEL - SHORT-TERM

The Department of Correction should:

5. Canvass its ranks of officers who want to be assigned to observation and reception areas. Those with experience at Branch Queens should be contacted first.

As the Board noted in 1972:

> "Not every correction officer is capable of handling the delicate needs of suicide-prone inmates. Yet, the present practice seems to be to assign correction officers randomly to floor areas, with no regard for the individual

correction officer's ability, and with no special effort to train the correction officer to recognize and deal with mentally disturbed inmates or emergency situations."

6. Assign steady tours to correction officers who want to do this kind of work in mental observation and reception areas.

7. Ensure command accountability in all institutions by assigning superior correction officers to check that tours are being made much more frequently and to be responsible for the performance of correction officers and suicide prevention aides in their charge.

8. Assign additional suicide prevention aides so that Recommendation No. 7 can be accomplished.

D. PERSONNEL - LONG-TERM

9. Observation in special areas to be conducted under a crisis intervention team concept.

Correction officers should be specially trained and permanently assigned to mental observation areas, where they can deal personally with disturbed or suicide-prone inmates. The balance of the team should be composed of inmates, medical staff, mental health staff and representatives of any other inmate service agency, if necessary. Supervisory personnel should be assigned accordingly.

10. Special attention should be paid to the selection, training, and supervision of suicide prevention aides, inmates assigned to assist staff in helping prevent such deaths.

This program worked well for a sustained period after its introduction into the system in 1972. Recently, however, the selection of aides has been taken over by correction officers rather than mental health personnel. Too often criteria other than the inmate's suitability for this kind of work has been used. Every effort should be made to return to the original conception of the program.

On balance, the Board's 1973 recommendations on the Inmate Suicide Prevention Aide Program are still timely:

-- The mental health staff at each institution should be responsible for the selection, instruction, and supervision of suicide prevention aides. One member of the mental health staff should be assigned to the institution's suicide prevention program as his primary responsibility. It should be this mental health worker's responsibility to:

(a) interview candidates for suicide prevention aide positions and recommend inmates for appointment to the head of the institution or to a Deputy Warden, Assistant Deputy Warden, or Captain delegated by him to exercise correctional responsibility over the program. Recommendations should be made after consultation with correction officers and inmates who are familiar with the potential aides;

(b) organize and develop a program of orientation in which each newly assigned aide is full instructed as to his duties;

(c) schedule and conduct regular discussion sessions among aides, mental health workers, psychiatrists, psychologists, and correction officers in which individual inmate cases are reviewed and common problems discussed.

(d) monitor periodically the work of aides assigned to particular areas and seek out reports from correction officers regularly assigned to the area on aides' performances.

E. COMMUNICATION - SHORT-TERM

11. The Department should redistribute General Order No. 26 of 1973, "Assessment of Suicidal Risks in Prison."

12. Institutional mental health and medical staff should make every attempt to inform correction personnel of suicidal inmates.

13. Correction officers should inform each other and the suicide prevention aides of information about inmates in their areas which was learned during the preceding tour of duty.

F. COMMUNICATION - LONG-TERM

14. A maximum effort should be made at all stages from initial arrest to transfer of custody to identify disturbed inmates and transmit vital information to all institutional personnel who come into contact with such inmates.

The information so transmitted must be translated into acceptable levels of care and supervision (1972, Board of Correction).

Clerks of the court should be obligated to report unusual or disturbed behavior of prisoners in a courtroom (1972, Board of Correction).

> --Those charged with delivering prisoners from the courts to an institution should report any observation of disturbing prisoner behavior so that the receiving officers can make appropriate classification assignments (1972, Board of Correction).
>
> --Develop a procedure for the recording of information on disturbed inmates and for the communication of such information among all correction and mental health personnel and Aides dealing with such inmates (1973, Board of Correction).

Furthermore, there is often no effort made to inform the correction officer about the particular condition of each suicide-prone inmate in the area to which he is assigned. In short, there is no concern for any stable, systematic observation of such inmates. The quality of such observation could be vastly improved by establishing a set of factors by which behavior could be measured, incorporating them into a form and requiring that all, not just unusual, behavior be recorded for analysis by professionals in the mental health field (1972, Board of Correction).

G. ADMISSION - SHORT-TERM

15. The Montefiore admission procedure should be adopted by Prison Health Services and deployed system-wide.

The Montefiore admission procedure represents a significant improvement over earlier methods. But, even under the triage system, particular attention must be given to follow-up treatments by both medical and mental health staff. A haphazard approach to this important function is not acceptable as it creates additional stress for the detainee. Special consideration has to be given to persons returning from outside institutions such as courts, hospitals, psychiatric wards, etc., or transferred from other Department facilities.

16. A simplified method of informing correctional staff of admission interview results must be devised.

H. ADMISSION - LONG-TERM

As the Board noted in 1973:

17. There must be a screening procedure in which an inmate is interviewed by a psychiatrist or psychologist or social worker or other trained personnel.

This procedure should be particularly intensive where a history of mental disorder is indicated. The results of this procedure should be decisive in determining the placement of the individual in a psychiatric ward, or a cell with a partner, or a solitary cell.

18. Ideally, detainees would be received into the penal system with dossiers compiled by the segments of the criminal justice system with which they have already come in contact.

This could include reports from the police, including statements from the complaining witness, if any were available, from the Pre-Trial Services Agency, from the judiciary, from legal counsel, from probation, and from any individual or agency who might help to properly classify the individual. Since defendants are committed to the custody of the Department of Correction at different stages of their judicial proceedings, every effort should be made to inform admission screeners of case progress, nature of charge, etc. Armed with that information and buttressed by professional, in-depth interviewing on location, there is little chance that an individual would be misclassified.

Reception and orientation area assignment could then be made rationally. Ideally, the process would take 10 to 14 days. Statistics have demonstrated that following incarceration, the first 10 days are a crisis period (Rand). Following adjustment to the new routine, the crisis abates, but recrudesces after 60 days.

--a program of orientation for prisoners should be organized so that prison discipline and expectations can be communicated and prisoners can have an opportunity to ask questions regarding their care (1972, Board of Correction).

19. Court returns should be especially watched, particularly when they have been convicted or sentenced.

--Inmates who return to the institution from prison psychiatric wards in outside hospitals should be recorded in a special log book in the receiving room, indicating the time of arrival and the times and locations at which each part of the admitting process is conducted. Mentally disturbed inmates returning to the institution should be referred to institutional mental health personnel immediately. No decision about the housing location of mentally disturbed returnees should be made unilaterally by correctional personnel. If mental health staff believe strongly that the inmate should be returned to the mental health unit, this should be done. If, because of overcrowding, the mental health staff feels that the inmate's condition is not serious enough to displace another inmate from the unit, immediate psychiatric attention should be assured for the inmate wherever he is housed. Every effort to have suicide inmates in the mental health unit must be made (1972, Board of Correction).